MEDI-CAL UPDATE Part 2
Billing and Policy
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Oupatient Services • Home Health Agencies and Home and Community-Based Services

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Contents

HIPAA-Mandated HCBS Waiver Code and Policy Changes

Effective for dates of service on or after November 1, 2006, the Home and Community-Based Services (HCBS) waiver program will update billing codes from interim HCPCS codes to national HCPCS codes to streamline the billing process.

All existing waivers remain valid until the date of their expiration.

A total of 15 new waiver procedure codes will correlate with select modifiers and provider types in order to produce one reimbursement rate. All HCBS interim HCPCS codes starting with the letter "Z" will be replaced by the national codes.

The HCBS waivers administered by In-Home Operations (IHO) are restructured to reflect the medical facility alternative that the waiver serves.

- **In-Home Medical Care (IHMC) Waiver:** This waiver remains unchanged. It serves disabled recipients who, in the absence of waiver services, would otherwise require acute hospital services for at least 90 consecutive days.
- **Nursing Facility Subacute (NF-SA) Waiver:** This new waiver serves disabled recipients who, in the absence of waiver services, would otherwise require adult or pediatric subacute NF inpatient services for at least 180 consecutive days.
- **Nursing Facility Level A and B (NF-A/B) Waiver:** This waiver replaces the Nursing Facility (NF) Waiver. It serves disabled recipients who, in the absence of waiver services, would otherwise require NF-A (intermediate care) or NF-B (skilled nursing facility) services for at least 365 consecutive days.
- **Model-Nursing Facility Waiver:** This waiver was terminated. Recipients were transitioned to either the NF-SA or NF-A/B Waiver based on the recipient's facility alternative level of care.

HCBS Waiver Services Eligibility

To receive HCBS waiver services, an individual must meet Medi-Cal financial eligibility requirements. Medi-Cal eligibility can be met through the regular Medi-Cal eligibility or the special waiver eligibility rules.

Regular Medi-Cal eligibility rules require the income and resources of the family in determining whether the potential waiver service recipient is eligible for Medi-Cal when residing in the home. The appropriate county welfare department or Supplemental Security Income (SSI) office is responsible for making Medi-Cal eligibility determinations.

Special waiver eligibility rules require only the income and resources of the individual seeking HCBS waiver services in determining Medi-Cal eligibility. When using special waiver eligibility, IHO first assesses the individual to determine if they meet medical necessity criteria. Once this determination is made, IHO then coordinates with the appropriate county welfare department for the Medi-Cal eligibility determination.

Please see **HIPAA**, *page 2*

HIPAA *(continued)*

The authorization of HCBS waiver services – to provide services in the home in lieu of institutional care – depends on the agreement of the following persons: the recipient, guardian or authorized representative, primary care physician and the HCBS waiver provider.

The IHMC, NF-SA and NF-A/B waivers can extend Medi-Cal eligibility to certain individuals who otherwise would not be eligible for Medi-Cal. The individual must have medical care needs that meet the waiver's medical facility alternative level of care requirements and is able to safely receive medical care services in his/her home and community in lieu of institutional care. To maintain a waiver recipient's enrollment in the waiver, it is required that at least one waiver service is rendered, billed and paid annually.

Waiver recipients must use Medi-Cal services prior to using waiver services. For example, waiver recipients 20 years of age and younger are eligible to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Private Duty Nursing (PDN) and Pediatric Day Health Care (PDHC) services.

The most frequently rendered, billed and paid waiver service for recipients who receive EPSDT PDN and/or PDHC services is Waiver Case Management.

Provider Definitions
Provider definitions have been added to the *HCBS Billing Codes and Reimbursement Rates* section:

"HCBS Waiver Registered or Licensed Vocational Nurse" means a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN) who provides individual nursing services and, in this capacity, is not employed by or otherwise affiliated with a Home Health Agency or any other licensed health care provider, agency or organization. An individual nurse provider may not be a parent, stepparent, foster parent, spouse or legal guardian of the patient.

"HCBS Waiver Registered or Licensed Vocational Nurse Services" means shift-nursing services provided to a recipient in his/her home by an individual nurse, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

"HCBS Benefit Provider" means a Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), or licensed psychologist who provides individual HCBS waiver services as described in the waiver's Standards of Participation (SOP), and is not employed by or otherwise affiliated with an agency or organization. A HCBS Benefit Provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of the patient.

"Professional Corporation" means a provider who employs a LCSW, MFT or licensed psychologist, meets the HCBS waiver provider requirements, and provides HCBS waiver services as described in the waiver's SOP.

"Home and Community-Based Services Nursing Facility" means a Congregate Living Health Facility that meets the HCBS waiver provider requirements and provides HCBS waiver services as described in the waiver's SOP.

"Home and Community-Based Services Personal Care Benefit" means an unlicensed individual who meets the HCBS waiver provider requirements and provides HCBS services as described in the HCBS waiver.

Scope of Practice by Provider Type
The following are new descriptions of a waiver provider's scope of practice.

Services provided by a Certified Home Health Aide under a waiver program include only those services described in *Health and Safety Code*, Section 1727.

Services provided by a LCSW under a waiver program include only those services described in the HCBS waiver and the *Business and Professions Code*, Section 4996.9, within the scope of practice of a LCSW.

Please see **HIPAA**, *page 3*

HIPAA *(continued)*

Services provided by a MFT under a waiver program include only those services described in the HCBS waiver and the *Business and Professions Code*, Sections 4980, 4980(b), 4980.02 and 4996.9 within the scope of practice of a MFT.

Services provided by a licensed psychologist under a waiver program include only those services described in the HCBS waiver and the Business and Professional Code, Sections 4980, 4980(b), 4980.02 and 4996.9, within the scope of practice of a licensed psychologist.

Services provided by a HCBS Nursing Facility under a waiver program include only those services described in the HCBS waiver and the *Health and Safety Codes* 1250(i), 1267.12, 1267.13, 1267.16, 1267.17 and 1267.19.

Prior Authorization
All HCBS services require an approved *Treatment Authorization Request* (TAR). The following HCPCS codes have a negotiated rate and always have a TAR Control Number (TCN) ending in "3": S5160, S5161, S5165 and T2035. If the TCN does not end in "3", contact the appropriate IHO office.

New Codes and Rates
The following *Code and Rate Correlation Table* correlates HCBS codes, provider types and modifiers with one rate of reimbursement.

Modifiers used in the *Code and Rate Correlation Table* are defined as follows:

Modifier	Definition
-TD	Registered Nurse.
-TE	Licensed Practical Nurse (LPN)/Licensed Vocational Nurse.
-TT	Additional patient. HCBS program usage: Shared services – HCBS Waiver services provided to two waiver recipients who reside in the same residence.
-U1	Medicaid level of service 1. Level of care – skilled nursing services A or B.
-U2	Medicaid level of service 2. Level of care – subacute.
-U3	Medicaid level of service 3. Level of care – acute.

Code and Rate Correlation Table

Procedure Code/Description **HCBS Usage**	**Provider Type**	**Required Modifier**	**Rates**
H0045 Respite care services, not in home, per diem.	CLHF (59)	-U1	$ 91.28
Intermittent or regularly scheduled temporary care and supervision provided to an individual in an approved out of home location, per day. For example, Congregate Living Health Facility (CLHF).	CLHF (59)	-U2	358.97
	CLHF (59)	-U3	490.60

Please see **HIPAA**, *page 4*

HIPAA *(continued)*

Procedure Code/Description **HCBS Usage**	**Provider Type**	**Required Modifier**	**Rates**
S5111 Home care training, family; per session. Family training services provided for the families of individuals served under the IHO HCBS waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. Session = One hour.	HHA (14)	None	$ 45.43
	HCBS RN (67)	None	35.77
S5160 Emergency response system; installation and testing. Installation and testing of a Personal Emergency Response System (PERS) for individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who: live alone or who are alone for significant parts of the day; have no regular caregiver for extended periods of time; and who would otherwise require extensive routine supervision.	Durable Medical Equipment (DME) (02)	None	Negotiated rate specified on TAR.
	Non-profit Proprietary Agency (95)	None	
	HHA (14)	None	
	Professional Corp (69)	None	
	HCBS RN (67)	None	
	HCBS Benefit Provider (68)	None	
S5161 Emergency response system, service fee, per month (excludes installation and testing). Personal Emergency Response System (PERS) is an electronic device that enables individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who: live alone or who are alone for significant parts of the day; have no regular caregiver for extended periods of time; and who would otherwise require extensive routine supervision. Monthly.	DME (02)	None	Negotiated rate specified on TAR.
	Non-profit Proprietary Agency (95)	None	
	HHA (14)	None	
	Professional Corp (69)	None	
	HCBS RN (67)	None	
	HCBS Benefit Provider (68)	None	

Please see **HIPAA**, *page 5*

HIPAA *(continued)*

Procedure Code/Description **HCBS Usage**	**Provider Type**	**Required Modifier**	**Rates**
S5165 Home modifications; per service. Environmental accessibility adaptations that consist of physical adaptations to the home, given the individual's unique physical condition and requirements necessary to enable the waiver recipient to receive care at home and to ensure the health, welfare and safety of the individual. Lifetime benefit limit.	DME (02)	None	Negotiated rate specified on TAR. Negotiated rate not to exceed lifetime benefit of $5000.
	Building Contractor (63)	None	
	Non-profit Proprietary Agency (95)	None	
	HCBS RN (67)	None	
	HCBS Benefit Provider (68)	None	
S9122 Home Health Aide or Certified Nurse Assistant, providing care in the home; per hour. Individual private duty services provided by a Certified Home Health Aide (CHHA) who is employed by a Home Health Agency and supervised by a Registered Nurse; per hour.	HHA (14)	None	$ 18.90
	HHA (14)	-TT	20.79
S9123 Nursing care, in the home; by Registered Nurse, per hour (use of general nursing care only, not to be used when CPT-4 codes 99500 – 99602 can be used). Individual private duty nursing services provided by a Registered Nurse for individual and shared nursing care.	HHA (14)	None	40.57
	HCBS RN (67)	None	31.94
	HHA (14)	-TT	44.63
	HCBS RN (67)	-TT	35.13
S9124 Nursing care, in the home; by Licensed Practical Nurse; per hour. Individual private duty nursing services provided by a Licensed Vocational Nurse for individual and shared nursing care.	HHA (14)	None	29.41
	HCBS LVN (67)	None	24.42
	HHA (14)	-TT	32.35
	HCBS LVN (67)	-TT	26.86
T1005 Respite care services, up to 15 minutes. Intermittent or regularly scheduled temporary care and supervision provided to an individual in their home or in an approved out of home location. 1 unit = 15 minutes.	HHA (14)	-TD	10.14
	HHA (14)	-TE	7.35
	HHA (14)	None	4.72
	HCBS RN (67)	-TD	7.98
	HCBS LVN (67)	-TE	6.10
	Personal Care Agency (66)	None	2.63
	Employment Agency (64)	None	2.63

Please see **HIPAA**, *page 6*

HIPAA *(continued)*

Procedure Code/Description **HCBS Usage**	**Provider Type**	**Required Modifier**	**Rates**
T1016 Case management, each 15 minutes. Consists of the development of a treatment plan, ongoing case management activities and HCBS Registered Nurse supervisory activities of private duty services (individual or shared) provided by an HCBS LVN. 1 unit = 15 minutes.	HHA (14)	None	$ 11.36
	Professional Corp (69)	None	11.36
	HCBS RN (67)	None	9.94
	HCBS Benefit Provider (68)	None	9.94
T1019 Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility (ICF)/Measles-Rubella, Mentally Retarded (MR) or Institution for Mental Disease (IMD), part of the individualized plan of treatment (code may not be used to identify services provided by Home Health Aide or Certified Nurse Assistant). Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. 1 unit = 15 minutes.	HHA (14)	None	3.62
	Personal Care Agency (66)	None	3.62
	Employment Agency (64)	None	3.62
T2025 Waiver Services; not otherwise specified (NOS). Used for the coordination of waiver service needs for individuals who have complex medical services with multiple funding through public and private sources; per hour.	HHA (14)	None	45.43
	Professional Corp (69)	None	45.43
	HCBS RN (67)	None	35.77
	HCBS Benefit Provider (68)	None	35.77
T2033 Residential care, not otherwise specified (NOS), waiver; per diem. Private duty nursing services provided by a CLHF; per day.	CLHF (59)	-U1	91.28
	CLHF (59)	-U2	358.97
	CLHF (59)	-U3	490.60

Please see **HIPAA**, *page 7*

HIPAA *(continued)*

Procedure Code/Description **HCBS Usage**	**Provider Type**	**Required Modifier**	**Rates**
T2035 Utility services to support medical equipment and assistive technology/devices, waiver. Reimbursement to the individual for utility costs limited to the portion of the utility costs attributed to the use of life sustaining equipment, such as ventilators, suction machines, monitors and feeding pumps. Assistive technology/devices are not covered by this waiver. Requests for less than $20 per month will not be approved. Monthly.	HHA (14)	None	Negotiated rate specified on TAR Minimum – $20/month Maximum – $75/month
	Professional Corp (69)	None	
	HCBS RN (67)	None	
	HCBS Benefit Provider (68)	None	
T2038 Community transition, waiver, per service; per hour. Transitional Care Management (TCM) services provided to transition an IHO HCBS waiver eligible individual from a health facility to a home and community-based setting. This includes the assessment of the individual's medical and non-medical needs, supports in the home and funding. TCM services may be provided up to 180 days before discharge from an institution.	HHA (14)	None	45.43
	Professional Corp (69)	None	45.43
	HCBS RN (67)	None	35.77
	HCBS Benefit Provider (68)	None	35.77
Long Term Care (LTC) interim code (depending on level of care). Intermittent or regularly scheduled temporary care and supervision provided to an individual in an approved LTC facility; per day. LTC facilities will submit prior authorization requests using a Long Term Care TAR form (20-1) and submit claims on the *Payment Request for Long Term Care* (25-1) claim form.	LTC Facility (17)	None	Contracted Medi-Cal daily per diem.

Updated manual replacement pages will be published in the October *Medi-Cal Update*.

Primary Diagnosis Code Changes for GHPP Claims

Effective September 1, 2006, claims for reimbursement of Genetically Handicapped Persons Program (GHPP) services may be billed with a primary diagnosis code that reflects the condition for which the client seeks medical help. Previously, the primary diagnosis was limited to the ICD-9 code for the condition that qualified the client to participate in the Genetically Handicapped Persons Program.

For example, under the new policy if a client qualifies for GHPP due to cystic fibrosis (ICD-9 code 277.0) but presents to the doctor with the flu (ICD-9 code 487), then the code for the presenting condition would be entered as the primary diagnosis code. The code for cystic fibrosis would be entered as a secondary diagnosis.

This information is reflected on manual replacement pages genetic 5 and 6 (Part 2).

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions
The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71
238.72	238.73	238.74	238.75
238.76	238.79	277.30	277.31
277.39	284.01	284.09	284.1
284.2	288.00	288.01	288.02
288.03	288.04	288.09	288.4
288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64
288.65	288.69	289.53	289.83
323.01	323.02	323.41	323.42
323.51	323.52	323.61	323.62
323.63	323.71	323.72	323.81
323.82	331.83	333.71	333.72
333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19
338.21	338.22	338.28	338.29
338.3	338.4	341.20	341.21
341.22	377.43	379.60	379.61
379.62	379.63	389.15	389.16
429.83	478.11	478.19	518.7
519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11
523.30	523.31	523.32	523.33
523.40	523.41	523.42	525.60
525.61	525.62	525.63	525.64
525.65	525.66	525.67	525.69
526.61	526.62	526.63	526.69
528.00	528.01	528.02	528.09

Please see **ICD-9 Codes**, *page 9*

ICD-9 Codes *(continued)*

Additions (continued)

538	608.20 *	608.21 *	608.22 *
608.23 *	608.24 *	616.81 **	616.89 **
618.84 **	629.29 **	629.81 ** +	629.89 **
649.00 ** +	649.01 ** +	649.02 ** +	649.03 ** +
649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +
649.13 ** +	649.14 ** +	649.20 ** +	649.21 ** +
649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +
649.40 ** +	649.41 ** +	649.42 ** +	649.43 ** +
649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +
649.60 ** +	649.61 ** +	649.62 ** +	649.63 ** +
649.64 ** +	729.71	729.72	729.73
729.79	731.3	768.70 #	770.87 #
770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91
784.99	788.64	788.65	793.91
793.99	795.06 **	795.81	795.82
795.89	958.90	958.91	958.92
958.93	958.99	995.20	995.21
995.22	995.23	995.27	995.29
V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31
V58.32	V72.11	V72.19	V82.71
V82.79	V85.51	V85.52	V85.53
V85.54	V86.0 ** +	V86.1 ** +	

Restrictions

*	Restricted to males only
**	Restricted to females only
#	Restricted to ages 0 thru 1 year
+	Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Instructions for Manual Replacement Pages — Part 2

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Remove and replace: genetic 5/6